Deaf Youth Retreat

Oct 27-29
2017
Deadline Oct 18th

Office Use

(Sponsored by Deaf Youth Camp)

Ages 10 – High School

Registration Form

Name	Age	Male	Female
Address			
City	State	Zip	

Parent/Guardian

Name		Home Phone			
Email	Work Phone		Mobile Phone		
Address	City		State & Zip		
Name of Employer	Family's Religious Preference				

Check all that apply.
Does the camper use:

ASL	PSE	SEE	Lip read	Both	Oral

Does camper use a sign language interpreter at school?

Yes	No

Emergency Contact ***If parent or guardian cannot be located, in case of emergency***

Name	Contact Number
Persons authorized to take child from camp (other than parent/guardian)	
Persons not permitted to take child from camp	

Authorization to participate in camp activities and pictures

I hereby give permission for my child to go on field trips away from camp premises, whether on foot or by vehicle. Photograph/Video –Deaf Youth Camp may produce a video of the weekend and/or put pictures of different activities on DYC website. *(No names will be used.)*

Parent or guardian signature *Date*

Registration Form

Participants' Name

I have completely read and agree with all the above form. I have entered all that pertain to my child correctly and completely to the best of my knowledge.

I further agree to indemnify and hold harmless DYC & Baptist Hill from all claims, demands, suits, causes of action, or judgments which camper ever had, now have, or may have in the future or which camper's heirs, executors, administrators, or assigns may have, or claim to have against DYC and/or Baptist Hill arising out of or in any way connected with the camp week, for all personal injuries, known or unknown, property damages, or claims for wrongful death, causes by the acts, omissions or negligence of DYC and/or Baptist Hill and on behalf and in DYC &/or Baptist Hill's name, defend at my own expense any such claims, demands, suits, causes of action, or judgments described above.

For the safety and general welfare of all participants, the camp reserves the unrestricted right to dismiss a participant whose conduct or influence, in the opinion of the Director is detrimental to the best interest of the camp.

Camp is not responsible for participants' articles of clothing or personal belongings. It is strongly recommended that participants **Do Not** bring valuable items (cell phones, IPods, electronic games, tablets, NOOK, etc.).

_____ _____

Signature *Date*

(Relationship) _____

Please list as much as possible about your insurance and the deductible. Send copy of your registration and complete Health form and payment to:

Victoria Towobola
609 N. Spring Lake Dr.
Independence, MO 64056

Registration fee: $50.00

Checks or Money Orders should be made out to: Deaf Youth Camp

DEADLINE for receiving application and fee is Oct 18th, 2017

Refund Policy

No refund after Oct 18, 2017

I understand that in the event of the withdrawal, dismissal or absence of my child after Oct 18, 2017, no portion of the registration fee will be refunded or waived. There will be no refund to families or guardians, whose child are withdrawn or are dismissed during the retreat. I have read and agreed to the terms of the Refund Policy.

_____ _____

Signature *Date*

(Relationship) _____

Deaf Youth Retreat

Office Use

Permission form and Health form

Check the box for nurse authorization – please sign and date

Participant Name	Birth date / /

Insurance

Blood Type

Name of policy holder _____ Phone _____

Policy/Group # _____

Type of coverage _____

Please include a copy of your insurance card.

Immunization Record

Vaccine	Month and Year
Diphtheria-Tetanus-Pertussis	_____
Tetanus – Diphtheria (TD)	_____
Tetanus	_____
Polio	_____
Measles (Hard, Red)	_____
Rubella (German)	_____
Mumps	_____
Other	_____

Emergency Contact

If parent or guardian cannot be located, in case of emergency please contact:

Name	Contact Number
Persons authorized to take child from camp (other than parent/guardian)	
Persons not permitted to take child from camp	

Check all that have

Allergies	Bee sting	Poison Ivy	Penicillin	Poison Oak	Sumac	Dust	Epipen

Check all that have or use

Hearing aid	*Cochlear Implant*	*Asthma*	*Inhaler*	*Nebulizer*	*Diabetic*	*Sunburns easy*
Skin sensitivity due to other medical condition					Eczema	

Participant Name

Medications

Name of Medication	Dosage	Time administered/X per day	Office Use

Please list all medications your child will be taking while attending the retreat.

ADMINISTRATION OF OVER-THE-COUNTER MEDICATIONS

The following information must be completed and signed by parent/guardian in order for any over-the-counter medication to be administered at Deaf Youth Retreat. All medications will be administered by a Registered Nurse.

The over-the-counter medications will be available in the Nurse's Office during retreat. In order for your child to receive medication, **parents must authorize *each medication* by initialing the box next to the medication name below.** All medications will be administered according to the package dosage directions only. Participants are not permitted to self-medicate with any over-the-counter medications while attending Deaf Youth Retreat.

You may choose to decline any medication be given without verbal/phone consent from you to the nurse. If that is your wish, please clearly mark REFUSE MEDS at the bottom of this form.

Parent Initial	Name of Medication	Parent Initial	Name of Medication	Parent Initial	Name of Medication	
	Advil		Maalox		Excedrin Migraine	***Office Use***
	Tylenol		Gas X		Robitussin	
	Aleve		Mylanta		Halls Cough Drops	
	Ibuprofen		Tums		Chloraseptic Spray	
	Excedrin		Pepcid AC		Antibiotic Ointment	
	Bufferin		Rolaids		Caladryl Lotion	
	Motrin		Benadryl		Gaviscon	
	Imodium A-D		Sudafed		Emmetrol	
	Pepto-Bismol		Claritin/Loratidine		Midol	
	Zantac		Lotion with Lidocaine			

Participant Name

In the event I cannot be reached in an emergency, I hereby give permission for the physician selected by the Administrator or camp nurse, to hospitalize, secure proper treatment for and to order injection, anesthesia or surgery for my child and will accept all of the expenses of emergency medical or surgical treatment. I have informed Deaf Youth Camp of any special medical needs of my child and have provided them with complete and accurate instructions regarding those needs, including any necessary and lawfully prescribed drugs for my child. I authorize DYC and Baptist Hill and its employees and agents to dispense medications and attend to other special needs of my child. I give Missouri Deaf Youth Camp's nurse permission to administer all medicines listed as per directions on container or written out by parent/guardian.

Signature _____

(Relationship) _____